Untangling health care

By William H. Foege

To benefit from medical science, it matters where you are born and the wealth of your family. My experience in global health teaches me that the worst scenario is to be born poor in a poor country. But even in the United States, we have not figured out how to deliver the benefits of science to our poorest people.

The debate has continued for decades. Each issue of the American Medical Association News in the early 1960s covered the latest infighting as Congress grappled with the problem: What to do with Americans who had too many resources to be classified as indigent, but too few resources to afford health care. Sound familiar?

Despite more than 45 years of argument and the creation of Medicare and Medicaid, our government and medical establishment still haven't been able to provide adequate care to all Americans. At first, doctors feared the advent of socialized medicine. Now, it is often stated that the medical profession, while looking over one shoulder to guard against socialism, was totally blindsided by the slow advance of capitalism.

Not-for-profit hospital and health programs have been sold to for-profit groups and the battle continues between profit and quality care. It is a one-way street. For-profit groups will never sell to not-for-profits. The results are exceptional medical care for some, but not for all, and an unmet challenge in containing costs while providing universal coverage.

Public health efforts, which seek to improve the health of entire communities, have been financed in a different way — through taxes — but that does not mean it has been more logical. Two changes would be reasonable.

First, programs where financial benefits outweigh costs should become entitlements. Immunization programs are a good example. Every dollar invested provides savings that exceed a dollar. Programs like this should not have to compete with other items in government budgets. When we don't fully fund such programs, we are deciding in advance to spend even more money than the programs would cost, and to do so without reaping the programs' benefits.

The other change would be to index public health expenditures to total health expenditures. Through the years, there have been many examples of public health programs established only to be reduced the next year for lack of funding.

For example, through several disease cycles, measles programs received federal funding when measles cases were high, only to have funding cut when case reports went down. Inevitably, the cuts resulted in a resurgence of measles and the need to again build the infrastructure. Finally in the early 1980s, stable funding for measles was secured and transmission of the virus was interrupted in this country.

Apparently, we have to learn this lesson anew with every public-health problem. Emergency problems, whether SARS or influenza, often lead to an increase of funds on a short-term basis, followed by a reduction in funds when the emergency is over, resulting in the dismantling of the infrastructure.

To be prepared for problems such as emerging infections or bioterrorism, an ongoing infrastructure is required. In the same way we fund fire stations at airports even if years pass without a plane crash, funding stability for public health is crucial. Unfortunately, the current approach results in a rusting of the structure between emergencies. Indexing would prevent such inefficient starts and stops, allowing states to develop sustainable programs and the ability to plan public-health activities for the future.

As for individual health care, it is likely that corporations, led by the auto industry, will convince politicians that they cannot compete with foreign companies if saddled with health-care costs. This eventually will lead to a single-payer system instituted by government and paid for through taxes, as with public health.

In any model, however, the question remains: Can a market-driven system improve our level of health? Or does profit, as a bottom line, always reduce quality and cause rationing of services, exclusion of groups?

Two decades ago, the corporate world sought answers via a "report card" called the Health Plan Employer Data and Information Set, or HEDIS. Devised to measure and compare quality within health plans, the

system was a reasonable start, but it doesn't provide the answers we need. That's because rather than measuring health outcomes, HEDIS relies heavily on measuring processes, such as the percentage of children being immunized and the percentage of women receiving pap smears.

Why?

We know how to measure processes. It's much more difficult to measure health outcomes. And, yet, it's better health outcomes — such as freedom from heart attacks and cancer — that we want from our health coverage, not simply more health processes.

Recent attempts to improve matters have focused on quality, cost and *access* to care, when they should be focusing on quality, cost and *outcomes*. There is a difference, as the United Kingdom demonstrated with immunization. After the U.K. health system shifted its focus from ensuring access for everybody to granting rewards to physicians based on the number of shots given, immunization rates soared.

American health care might also take a lesson from the World Bank, which pioneered a tool in 1993 to measure the state of health in populations. Called "Disability Adjusted Life Years," or "DALYs," this metric incorporates rates of suffering and death into a single number, making it possible to see and compare the impact of various health problems and interventions among populations.

For example, this tool can provide analysts with a snapshot of the total disease burden of an area and the contribution of various factors, such as cancer, infections, and so on. Because it allows comparisons, it has been used by organizations such as the World Health Organization to set priorities for investment in health improvements.

DALYs still lack important ingredients such as measures of quality of care or feelings of well-being. Health is more than the absence of disease. Also, the DALYs metric doesn't reflect the relative values that various societies place on different kinds of suffering or the relative values they assign to life at different ages. Still, experience with the DALYs tells us that it's possible for economists to develop a metric called Disability Adjusted Health Outcomes as a way to measure and compare the effectiveness of the care we pay for.

With such a tool in hand, health plans could be reimbursed based on their ability to achieve those outcomes. The marketplace would then shift focus from process measures to improvement of health. Comparing how various health plans stack up in terms of millions of "person-years" of health experience would quickly reveal which plans are doing best. Thus, the marketplace would be harnessed to improve health profiles nationwide.

Health plans could be reimbursed with bonuses for the improvement of conditions that are lowering population-wide health measures. This would cause health plans to enroll sick people and provide smoke-enders programs, exercise and diet programs, as well as superb diabetes-control programs.

Imagine competing to enroll the disenfranchised, with current Med-icaid funds subsidizing their premiums! Suddenly, the marketplace would incorporate prevention into medical practice. Imagine if the marketplace succeeded where current medical care failed!

The major argument against such a plan is that we can't agree on defining or measuring health outcomes. If that is actually true, it means we are in a business where we don't know how to define success.

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